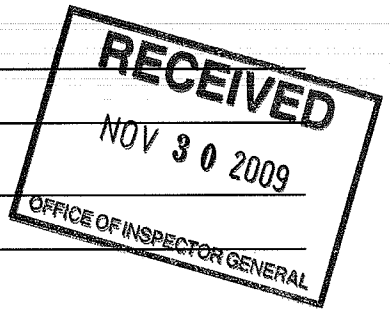
Application for License to Operate a Long-term Care Facility

For Office Use Only
Received 11/30/09
Amount $1980.00 Ck# 527005038



I. IDENTIFICATION

Name: Hurstbourne Care Centre at Stony Brook

Address: 2200 Stony Brook Drive

City/County/Zip: Louisville, Jefferson County, KY 40220-4016

Telephone number: 502.495.6240

Administrator: 502.495.0324

Date facility operation began at current address: 1991

Date facility began operation under current owner: August 1, 2004

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled		
Nursing Home		
Nursing Facility	132	132
Intermediate Care		
ICF/MR		
Personal Care		

II. CONTROL (check one in each column)

State	✓ Profit	Individual
County	Nonprofit	Partnership
City		Corporation
✓ Private		✓ Limited Liability Company

II. OWNERSHIP

Name and address of individual owner, partners or corporation. If partnership, list partners.

Hurstbourne HealthCare, LLC
2200 Stony Brook Drive
Louisville, KY 40220-4016

(OVER)

If facility owned or leased by a corporation, complete the following:

Name of corporation Not applicable

Address of corporation _____

President or Chairman _____

Vice President _____

Secretary _____

Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent	Consulting Management Company
Centennial HealthCare Holding Company, LLC	Shoreline Healthcare Management, LLC
303 Perimeter Center North, Suite 500	10210 Highland Manor Dr., Suite 260
Atlanta, GA 30346	Tampa, FL 33610

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.

Signature of authorized representative

Administrator
Title

11-13-09
Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)